



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

VISTA HOSPITAL OF DALLAS  
4301 VISTA ROAD  
PASADENA TX 77504-2117

#### **Respondent Name**

CONTINENTAL INSURANCE CO

#### **Carrier's Austin Representative Box**

Box Number 47

#### **MFDR Tracking Number**

M4-06-2307-01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "The most common CPT codes utilized by Vista Hospital of Dallas involve treatment, services and supplies that do not have a maximum allowable reimbursement (MAR). Therefore, Vista Hospital of Dallas made an extensive review of payments and reimbursements made by various Carriers from the geographical area of Texas for treatment, services and supplies utilized for both work-related and non-work related injuries. As a result of that review, Vista Hospital of Dallas was able to determine the usual amounts reimbursed by Carriers for treatment, services, and supplies from Vista Hospital of Dallas for both work-related and non-work related treatment in the state of Texas at their facility."

**Amount in Dispute:** \$9,698.25

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Commission Rule 133.307(g)(3)(D) states, 'if the dispute involves health care for which the commission has not established a maximum allowable reimbursement, [the requestor shall file] documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with § 133.1 of this title and § 134.1 of this title.' Vista has simply not met its burden of proof under Rule 133.307(g)(3)(D) to establish that reimbursement of at least \$11,925.00 meets the statutory standards under the Act for reimbursement of outpatient facility charges for a lumbar injection. On the contrary, this amount is grossly excessive as established by the Commission's inpatient surgical per diem rate; the Medicare rate; and finally, the proposed rate under the outpatient hospital facility fee guideline being drafted by the Commission. For these reasons, Vista has not met its burden of proof to establish that the requested reimbursement complies with the Act's statutory standards for reimbursement and that Carrier's rate of payment does not. Therefore, Vista is not entitled to additional reimbursement."

**Response Submitted by:** Stone, Loughlin & Swanson, LLP, PO Box 30111, Austin, TX 78735

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 4, 2005	Outpatient Surgery	\$9,698.25	\$0.00

## ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 TexReg 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. This request for medical fee dispute resolution was received by the Division on December 1, 2005. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 Texas Register 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor December 12, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - M – No MAR
  - \*850-054) – The recommended payments above reflect a fair, reasonable and consistent methodology or reimbursement pursuant to the criteria set forth in Section 413.011(D) of the Texas Workers' Compensation Act.
  - CNA Claims Plus payment was made in accordance with Section 413.011(b)(d) of the Texas Worker's Compensation Act. No additional payment is warranted. Full fair and reasonable has been paid. Audit stands as completed.

### **Findings**

1. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
  - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
  - Documentation of the comparison of charges to other carriers was not presented for review.
  - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
  - The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 TexReg 6276 (July 4, 1997). It further states that "Alternative methods of reimbursement were considered... and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges..." 22 TexReg 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
  - The requestor has provided select exhibit pages from the alleged managed care contract referenced above; however, a copy of the contract referenced in the position statement was not presented for review with this dispute.
  - Review of the exhibit pages submitted by the requestor finds a schedule of charges, labeled exhibit "A", dated 04/23/92, which states that "OUTPATIENT SERVICES: 101/401 PAY 70% OF BILLED CHARGES."
  - The requestor submitted a letter of clarification dated July 30, 1992 indicating a change in reimbursement to the above referenced contract, stating in part that "services rendered to eligible Beneficiaries will be considered at 80% of the usual and reasonable charge which is equal to the lesser of the actual charges billed by HCP; OR the eightieth (80th) percentile for charges for such services as set forth in the current Medical Data Research Database."

- The requestor submitted a fee schedule page, labeled exhibit A, dated effective August 1, 1992 which states, in part, that the provider shall receive “an amount equal to eighty percent (80%) of the Usual and Reasonable Charge for those Covered Services. For all purposes hereunder, the Usual and Reasonable Charge for such services shall be equal to the lesser of: (i) the actual charges billed by HCP for such services; or (ii) the eightieth (80th) percentile for charges for such services as set forth in the current Medical Data Research database.”
- No data or information was submitted from the Medical Data Research database to support the requested reimbursement.
- No documentation was presented by the requestor to support that the referenced contract was in effect at the time of the disputed services.
- While managed care contracts are relevant to determining a fair and reasonable reimbursement, the Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital's billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 Texas Register 6276 (July 4, 1997) that:  
 “A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.”  
 Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

### **Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

### **Authorized Signature**

Signature	Medical Fee Dispute Resolution Officer	October 6, 2011 Date
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### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c) ), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**